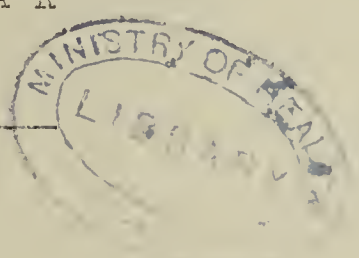
URBAN DISTRICT OF TORPOINT

THE
ANNUAL REPORT
OF THE
MEDICAL OFFICER OF HEALTH
FOR THE YEAR
1953



P.J. Fox,
M.B., B.Ch., B.A.O., D.P.H.

URBAN DISTRICT OF TORPOINT

ANNUAL REPORT OF THE MEDICAL OFFICE OF HEALTH FOR THE YEAR 1953

Mr. Chairman, Ladies and Gentlemen,

Once again the time has come round to present my Annual Report, and through it to convey a picture, in a very general way, of the health of the community in that part of Cornwall which goes to make up Health Area No.7. during the year 1953. I am following again the practice of providing a general preface which will be common to all six County District Annual Reports. In it I shall endeavour to set down my impressions as I tend to see them for the greater part of my time - as an Area Medical Officer of Health to some 53,000 people in this part of the County. Where matters peculiar to any one County District arise, comment on them will appear in the body of the Annual Report of that particular district.

My main impression of public health in 1953 is one of little change. There were no marked improvements or advances, but small gains were recorded in some directions. Thus the corrected birth rate for the area was fractionally above the national figure at 15.6 per 1000 of population. The corrected death rate of 10.7 per 1000 of population in the Area compares favourably with the national figure of 11.4 per 1000. Although only one maternal death occurred it was sufficient to produce a rate of 1.36 per 1000 total births as against the national rate of 0.76 per 1000 total births The stillbirth and infant mortality rate were both lower than the corresponding rates for England and Wales. Something of a set-back was experienced in tuberculosis where the total of cases notified was the highest for at least five years, and was in fact some 30% above the average total for the previous five years 1948-52. I shall deal with this matter in greater detail later in this preface. The estimated mid - 1953 population of the Area at 53,276 showed a small decrease as compared with the figures of 53,520 for 1952. Of the individual County Districts which go to make up the Health Area, St.Germans R.D., Liskeard R.D., Saltash M.B., and Torpoint U.D. showed small increases. In no case were the figures sufficiently great to be of any significance or call for any comment. The birth rate was below the national figure of 15.5 per 1000, in St.Germans R.D., Torpoint U.D., Liskeard M.B., and Looe U.D., and above it in Liskeard R.D., and Saltash M.B. The death rate was below the national rate of 11.4 per 1000 in all County Districts with the exception of Liskeard M.B., where it was 18.6 per 1000. Looking no further than this one might conclude that the Borough of Liskeard was not a particularly healthy locality. On closer examination the real reason for this high death rate soon becomes apparent, and is seen to be directly due to the presence in the town of a hospital for aged and chronic sick persons, Lamellion Hospital. Prior to 1953 the deaths of patients in Lamellion Hospital were attributed to the district in which they previously resided. Towards the end of 1952 the the Registrar-General decided that in future all persons dying in Lamellion Hospital would be regarded as having their place of residence there, and in consequence their deaths would be for statistical purposes attributed to the Borough of Liskeard. Whilst it might be reasonable to so attribute the deaths of those who had spent many months or years prior to death in Lamellion Hospital or in the adjacent Part III accommodation in the Institution, it appears to me to be quite wrong to do so in those cases where the death had occurred within a short time of the person having been admitted from some district outside Liskeard Borough. It appears to me that some definite period of time should be set, inside which the person dying would be regarded as a temporary resident whose death would be transferred to the previous permanent place of residence. Such a dividing line might be set at six months, nine months or one year and it would avoid the present anomalous situation whereby the Borough of Liskeard is made statistically responsible for the death of a resident of some adjacent district who has been brought into Lamellion Hospital to breathe his last. If the public are to appreciate and trust the statistics which appear in official reports they must have some assurance that they are based on a sound and reasonable interpretation of facts. As the practice in the matter under discussion does not seem to me to measure up to these criteria I have taken it up with the General Registrar Office in the hope that a better and more exact method can be arrived at

As in previous years heart disease is the most frequent single cause of death in the Area, with cancer again in second place. Of the various well defined heart diseases the most numerous was coronary disease where the samll blood vessels supplying the heart itself become narrowed or blocked. Recent research into the association between occupation and this desease points to the fact that it appears to occur more commonly in those whose occupation is mainly sedentary. Thus in one interesting series it was found to be more common amongst drivers of London Buses than amongst their colleagues who worked as conductors. Other recent work points to heavy consumption of tobacco as a possible aggravating factor in this disease. The cause or causes of cancer still remain obscure. Whilst cancer of the stomach remains the most frequent type of fatal cancer in this Area there has been a noticeable increase in deaths from cancer of the bronchus and lung from 5 in 1952 to 14 deaths in 1953. As most of you are aware, there is a very strong presumption that heavy consumption of tobacco, particularly in the form of cigarettes, over a long period is a cause of bronchial and lung cancer. This belief has very recently been strengthened by the preliminary results of an enquiry and investigation which has been taking place into the smoking habits of members of the medical profession in this country. Without wishing to appear an alarmist on this subject, I think it is only reasonable to again remind all who use tobacco, and especially those adolescents, and young adults who will use it over a long span of years, that its consumption in large amount may be fraught with the danger of producing cancer of the bronchus or the lung, and to counsel moderation at least if abstinence cannot be achieved. One hopes that all the prominence recently given to this subject will stimulate further enquiry and research into it more especially as the powerful tobacco industry both here and in the United States has contributed a large sum of money to finance research. It is possible that such research will free tobacco of the suspicion that it can cause fatal disease, or it may suggest methods of removing the offending constituent, without destroying its widespread appeal.

Much has been written in recent years about the possibility, and even more the probability that tuberculosis will be eradicated in the foreseeable future. Tuberculosis has been and still is for the majority of its victims a chronic, disabling disease whose course is measured in months and years. Not so very long ago its outcome was frequently fatal, but in the period since the end of the last war notable advances in the treatment of tuberculosis have reduced the mortality. Thus in Cornwall the death rate for tuberculosis in 1952 was about half that of the year 1946, and the same is true if the figures for England and Wales are examined. This appreciable and very welcome reduction in mortality has infused into the outlook on tuberculosis a feeling of optimism that the turning in the long and tragic land of tuberculous disease has been reached, and that the end for which so many generations have striven is in sight. There has been a tendency in some quarters to draw from the improvement in mortality a conclusion that the situation in tuberculosis is showing a general all round improvement. Unfortunately this is not so since the incidence of the disease, as measured by new cases notified, shows no reduction. This is true of local figures for this Health Area, and for the larger numbers involved in the County, and the country as a whole. During the five year period 1948-52 the average number of new cases of tuberculosis notified in No. 7 Health Area each year was 51, and in none of these years did the total differ appreciably from the totals for other years or from the average for the five years. It is therefore true to say that whereas mortality has been falling, the number of people contracting the disease showed no reduction over the period 1948-52. It is therefore not suprising to find that in 1953 there was no reduction in the incidence of tuberculosis in this Area. On the contrary there was a moderate increase, the total of 63 new cases representing a 24% increase over the average for the previous five years, and being 9 above the previous highest total of 54 cases in 1952. It would obviously not be reasonable or wise to take an unduly pessimistic view of these figures which are for one year only. It may well be that in 1954 the situation will improve and figures will return to a more normal level. Nevertheless it appears that there is at present no justification for much of the optimism which the reduced mortality rate has engendered. Tuberculosis is still prevalent to the extent that every year out of every thousand people in this Area one or two contract the disease and are thereby disabled for a long period, and become potential sources of infection to others.

At this point it is appropriate that the possible causes for the increased incidence of tuberculosis be examined, and here we leave the certainty of facts and figures, and enter the realms where conjecture plays a large part in providing the answer to our questions. I think it is reasonable to suppose that no single cause is responsible for the increase, and to state further that the broad general reasons for the increase are twofold. In the first place there probably has been some real increase in the amount of tuberculous infection in the community, but it is unlikely that this accounts for all the increase in the incidence of the disease. In the second place better and more efficient methods of recognising the disease have been responsible for the bringing to light of cases which were previously overlooked. Some two years ago the Chest Clinic services in East Cornwall were reorganised and based on Plymouth instead of West Cornwall. When this reorganisation took place Dr. J.C. Mellor was appointed as Chest Physician to a Clinical Area which included East Cornwall. About the same time the Cornwall County Council appointed a full-time Tuberculosis Health Visitor, Miss. S.L. Luxton. By their enthusiasm and hard work Dr. Mellor and Miss Luxton have provided an excellent service for handling cases of tuberculosis and their contacts and considerable assistance and advice has been given to the family doctor in this important matter. I believe that as a result of this, the family doctor has not hesitated to refer doubtful or chronic cases of chest ailments to the Chest Clinic and in that way some new cases of pulmonary tuberculosis have been discovered. Whilst the immediate impact of such discoveries tends to depress our hopes of eliminating this disease, the long-term outlook is improved by the discovery and recognitition of such cases. Our main hope of controlling and eliminating tuberculosis lies in the early recognition and control of the affected individual and the careful checking and surveillance of the close contacts at least. Ideally all known regular cont acts of any new case of tuberculosis should be examined and checked in an endeavour to find a possible source of infection and to discover any other individuals who had been infected either by our newly discovered case or by the original infecting source. Unfortunately this procedure is so difficult to put into effect as to be almost impossible, and at present our control and surveillance of cont acts is confined to close family associates of the case, usually those living in the same house. We do recognise, and this is especially true of tuberculosis in young, and previously active adolescents and adults, and there may be a wide circle of contacts beyond the family which is not checked or investigated. The main reason for not checking contacts in this wider circle is one of manpower, since to carry it out thoroughly and conscientiously would require a large staff of health visitors, and Chest Clinics would necessarily be involved in attending to the large number of contacts. An additional reason is the undesirability of disseminating widely the fact that any individual is suffering from tuberculosis. In the circumstances contact tracing is confined to the relatively restricted circle of relatives with whom the patient has been in close contact, and in which the chances of discovering the source of infection, and/or secondary cases of the disease would seem to be greatest. Nevertheless this does allow some sources of infection and/or secondary cases (themselves further potential sources of infection) to escape recognition, and thereby to act as reservoirs, and disseminators of infection. For this reason we must accept the probability that eradication of tuberculosis will be a slow and sometimes a discouraging business. On the other hand new methods of prevention and treatment of this disease, together with a more enlightened and intelligent outlook on the part of the general public, will as time goes by exert an increasingly favourable influence on the situation.

Whilst on the subject of specific preventive measures against tuberculosis I can report two encouraging developments. Early in 1954 all children in the school - leaving group i.e. all those who attain the age of 14 years during 1954, will be examined by mass-radiography, and if after this, and one further simple skin test, they are found suitable, they will be offered (subject to parental consent) B.C.G. vaccination against tuberculosis. This group has been selected because it is felt that adolescents when they leave school and commence work are exposed to a greater risk of tuberculous infection, without in many cases the opportunity to develop the adults power of resistance to the disease. Vaccination with B.C.G. enables them to safely and quickly acquire a reasonable degree of resistance to tuberculosis, and thereby reduce the tragic toll which the disease has always exacted amongst adolescents, and young adults. In

considering B.C.G. vaccination we ought in fairness tothis measure of prevention, try to understand the type of protection it affords, and the limitations which attach to it. Whilst it gives a good measure of protection against the amount of tuberculous infection encountered in normal everyday life, it does not guarantee protection against the less common occasions on which heavy infection is met with. As a corollary to this it can be said that B.C.G. vaccination should not be called upon to protect the individual from the consequences of a careless and irresponsible mode of living, which in adolescents, and young adults is best described as 'burning the candle at both ends'. Properly regarded as a help in the prevention of tuberculosis, I feel sure that B.C.G. vaccination represents a valuable new weapon in our fight against this disease.

I have written at some length about tuberculosis because in my view it represents one of the very few serious communicable diseases which remain as a challenge to public health and modern preventive medicine. In concluding this part of my report I should like to urge the need for taking, and holding a calm and balanced view on tuberculosis - neither being carried away by over optimism, nor allowing gloom and presimism to darken the picture. I believe that we can and will eradicate this wretched disease from our midst, but I feel sure the process will not be either rapid or easy.

Turning now to communicable diseases other than tuberculosis, the principal impression is that of epidemic measles in the first half of the year. In all 1565 cases were notified and this epidemic affected all districts in the Area with the exception of Torpoint Urban District. Pneumonia, whooping cough, and scarlet fever were all more prevalent than in 1952. There were three cases of diphtheria, of which two were in adults who had never been immunised. Two cases only of non-paralytic poliomyelitis were notified during 1953. In spite of the large influx of visitors into Cornwall during the summer holiday season three cases only of food poisoning were notified in this Area during the year.

During recent years outbreaks of food poisoning in various parts of the country have brought home to the general public and especially to those who participate in or are associated with commun al feeding in canteens and restaurants of one sort or another, the need for high standards of hygiene in the handling of food. This public interest has now progressed to the stage where, after fairly thorough investigations of the position, the Government has announced its intention to introduce new legislation which should ensure higher standards of hygiene in establishments where food is handled, and prepared for human consumption. At present legislation in this important sphere is ill - defined and generally unsatisfactory. Under the new legislation the most important provision will be that which will require the registration of all premises dealing with food for human consumption. This will give District Councils the right to satisfy themselves that premises and particularly catering establishments, are of adequate size and are reasonably equipped to handle food in a hygienic manner. At present it is difficult to insist on such reasonable standards and I have seen small catering establishments in which the amount of space devoted to the storage, preparation and cooking of food, and the cleansing, and storage of cooking utensils, and crockery, made it difficult if not impossible to maintain a reasonable standard of hygiene. Establishments of this type are in the minority, the majority of premises in which food is handled being reasonable in size and equipment. Owing however to the great influx of visitors into the County during the summer season, there is a distinct tendency for small, badly equipped establishments of this unsatisfactory type to spring hastily into existence at the beginning of the season with the intention of functioning for the summer season only. In such circumstances the proprietors are understandably not inclined or anxious to spend much on premises, and equipment, although in the course of four or five months a surprisingly large amount of food may be prepared and eaten in these places. Another difficulty which faces the catering industry springs from the seasonal fluctuation in trade. I refer to the necessity for engaging additional staff to meet the heavy summer demand on catering facilities, and here the difficulty of obtaining good, experienced employees for seasonal work is evident. This is unavoidable, but none the less unfortunate, since the commonest source of food poisoning is the inexperienced or careless food handler.

Premises, and equipment may be above reproach, but if the food handlers are inexperienced or careless the danger of an outbreak of food poisoning is always present. Apart from the obvious necessity of sparing the public the distressing and exhausting illness which results from contaminated food, the occurrence of outbreaks of food poisoning in a tourist and holiday area, such as Cornwall is, can have serious financial repercussions on the tourist industry. It is only fair to add that in the last five years the number of cases of food poisoning in this Area has been extrememly small, and in no case has any catering establishment been involved - a tribute to the good standards of cleanliness which exist in the catering industry. I trust these standards will be maintained in future years.

The Welfare of old persons continued to give some anxiety during 1953. In several cases old men and women were reported as living alone in squalid insanitary circumstances, with, in addition, an appreciable risk of fire existed a s a result of careless handling of oil lamps, candles, and paraffin oil. In almost all cases it was difficult or impossible to get relatives to undertake the care of or responsibility for these old persons. For much the same reasons which precluded relatives from helping - the senile, eccentric, and unreasonable attitude of most of these old people - it was not possible to find a home help who would face up to the task of cleaning up the home, and trying to get the old person to co-operate in keeping it reasonably clean. In the majority of cases, where it was felt that the old person could not continue to live at home, it was possible to persuade them to enter an institution or a hospital. In one case however an old man of 85 refused to see reason, and because of the filthy and insanitary conditions under which he was living application was made to a Court of Summary Jurisdiction under Section 47 of the National Assostance Act 1948. The Magistrates made an order for his removal and detention in Lamellion Hospital, Liskeard, where he subsequently remained of his own free will, without the necessity for having the order renewed.

I have written before of the importance of good housing in promoting and maintaining health and it is heartening to be able to report good progress on this front during 1953. In the rural districts it would appear that the numbers of new houses becoming available for letting are adequate to satisfy almost all the demands in those districts. In the urban parts of the Area the demand still exceeds the supply, but even here the clamour for rehousing is not so loud or insistent as in previous years. It is true of course that the higher rents and rates attaching to most Council houses deter many families who need rehousing from applying, and in that respect, the most easily available criterion of the need for rehousing - the list of applicants - is not completely reliable. Up to now the necessity for providing new houses to make up for the acute shortage caused by the war has been paramount and in this Area practically nothing has been done to clear districts where most of the dwellings are old and in such a state of dilapidation and disrepair that they cannot be reconditioned. Whilst such slum districts are neither numerous nor large in extent they do exist in the urban parts of this area, and now that the demand for new houses has eased consideration will have to be given to clearing these blocks of property, and rehousing the inhabitants, and it seems likely that in the near future the Government will press District Councils to produce schemes to deal with slum clearance.

During 1953 no scheme of major importance for water supply or sewage disposal was actually in hand although much work or planning and preliminary investigation of such schemes was undertaken in Liskeard, and St.Germans Rural Districts. In the former district further work on the comprehensive scheme to supply water throughout the Rural District from the river Fowey was more or less at a standstill pending the formation of a Joint Water Board. Although the need for proper systems of water supply, and sewage disposal is generally recognised, the very high cost of such schemes is one of the most difficult obstacles to their immediate and widespread implementation and here as in many other fields, projects have had to be graded in an agreed order of priority.

In this preface I have tried to put forward in a broad a manner as possible those aspects of public health practice and administration which have seened to me important during the year 1953. The views and opinions expressed are not original, though they are necessarily coloured or perhaps distorted, by my personal outlook. I have as far as possible tried to avoid dealing in matters of a controversial nature since I am conscious of my inability to take a truly impartial and unbiased view on such matters. I cannot conclude without expressing my thanks to members and officers of the six County District Councils I serve, for the kindness understanding and co-operation they have extended to me during the past year.

I have the honour to be

Your obedient Servant

P.J. FOX.

Medical Officer of Health.

TORPOINT URBAN DISTRICT

Area of Urban District	975 acres
Population (Registrar Generals Estimate)	6714
Number of Inhabited Houses	1133
Rateable Value of Urban District	£38,511
Sum Represented by Penny Rate	£157

Vital Statistics for 1953

	Male	Female	Total
Live Births	29	27	56

	Torpoint U.D.	Health Area No.7	England & Wales
Birth rate per 1000 of population	12.5	15.6	15.5

	Male	Female	Total
Stillbirths	1	1	2

	Torpoint U.D.	Health Area No.7	England & Wales
Stillbirth rate per 1000 of population	0.30	0.26	0.35

	Male	Female	Total
Deaths	19	23	42

	Torpoint U.D.	Health Area No.7	England & Wales
Deaths rate per 1000 of population	9.3	10.7	11.4

Deaths of Infants Under One year of Age

	Male	Female	Total
All causes	-	2	2

	Torpoint U.D.	Health Area No.7	England & Wales
Infant mortaility rate per 1000 live births	35.7	26.4	26.8

PRINCIPAL CAUSES OF DEATH AT ALL AGES.

Heart disease	12
Cancer (all sites)	10
Vascular lesions of the nervous system ('stroke')	6
Respiratory disease	4
Circulatory disease	3
Digestive disease	2

AVERAGE AGE AT DEATH

Males	Females
66	61

There is nothing in the foregoing statistics that calls for special comment. The birth rate is lower than that of the surrounding Health Area, and that of England and Wales, and is in fact the lowest of the six County Districts in the Health Area.

Some part of this reduction is probably due to the presence of an appreciable number of young umarried Service personnel in the population, although it must be realised that last year when the same conditions obtained the birth rate was slightly above the figures for the Area and the country as a whole.. Moreover the rate I have used is a corrected birth rate in which allowance in made for the presence of young married Service personnel in the population. The death rate is lower than the corresponding figures for the Health Area, and England and Wales. For the seventh successive year there wer no maternal deaths, but the infant mortality rate was somewhat above the area and national rates. The principal causes of death, heart disease, cancer, and 'stroke' were not so numerous as in 1952, although they maintained their place at the head of the list of principal causes of death in the Urban District.

INFECTIOUS DISEASE

In all 30 cases of infectious disease were notified during 1953. This is a reduction as compared with the 69 cases notified last year. The most prevalent infectious disease was measles, of which there were 19 cases. Two cases of diptheria, both of which occurred in unimmunised adults, were notified. It speaks well for the state of immunity of children, who used to be so susceptible to this disease, that the infection did not spread. There were no deaths from infectious disease during the year.

The following are details of actual numbers and case rates of infectious disease notified during 1953:-

Disease	Cases	Case rate per 1000 of population. Torpoint U.D.	Health Area No.7	England & Wales.
Measles	19	2.83	29.74	12.36
Pneumonia	6	0.89	1.41	0.84
Scarlet fever	3	0.45	1.20	1.39
Diphtheria	2	0.30	0.06	0.01

Tuberculosis During 1953 a total of 7 cases of respiratory tuberculosis, and 2 cases of non-respiratory tuberculosis were notified. This is a small increase over the total of 8 new cases notified in 1952. No deaths from tuberculosis were registered during 1953. At the end of the year 34 cases of respiratory tuberculosis, and 8 cases of non-respiratory tuberculosis were known to be resident in the Urban District. During the year 26 susceptible contacts of tuberculosis, all of them below the age of 15 years, were given B.C.G. vaccination.

The following are details of new cases and case rates during 1953:-

New Cases

Age Group	M.	F.
0 - 1	-	-
1 - 5	1	1
5 - 15	-	1
15 - 45	2	-
45 - 65	4	-
65 and over	-	-

Rate per 1000 of population

	Torpoint U.D.	Health Area No.7	England & Wales
New cases	1.34	1.18	Not stated
All cases	6.26	6.29	Not stated
Deaths	-	0.15	0.20

National Assistance Act, 1948 . No action under Section 47 of this Act was taken during 1953.

Water Supply. Apart from the fact that the Ministry of Housing and Local Government gave approval to the scheme for pumping water from a stream at Pool Farm Sheviock, to supplement the supply from Eglaroose Reservoir there is nothing of special interest to report. It was not found necessary

to restrict the use of water in any way during 1953.

Sewerage and Sewage Disposal. There are no changes or developments to report upon.

Food. The work carried out during 1953 in connection with food is set out in detail in the report of the Sanitary Inspector. Generally speaking the standard of bygiene in premises and in methods of handling food is reasonably good.

No cases of food poisoning were notified during the year.
No clean food campaigns were undertaken during 1953.

Housing. The erection of 20 Council Houses, and flats together with three Coronation Cottages for old persons was completed during the year, whilst a start was made on a contract for the building of a further 44 Council Houses, and flats. There is still a considerable demand for new houses in Torpoint, and if families, at present living in old sub-standard houses, and in that part of the town which will be cleared and re-developed, are to be rehoused there is every indication that Council housing schemes will have to continue for some years.

Factories Act 1937.

No difficulties were experienced in applying the provisions of this Act during 1953.

Report of the Sanitary Inspector. This report by Mr. Wilson Hogarth M.R.S.I., C.S.I.B. the Council's Sanitary Inspector follows. I should like to take this opportunity of expressing to Mr. Hogarth my thanks for the assistance he has given me during the year 1953.

SANITARY INSPECTOR'S REPORT FOR 1953

Sanitary Circumstances of the Area

Water Supply.

The new water main linking the Admiralty Establishments within the Urban District with the City of Plymouth Water Supply was completed during the year.

An Inquiry by the Ministry of Housing & Local Government was held in connection with an Auxiliary scheme for the pumping of approximately 20,000 gallons of water per day for two or three months of the year from the stream at Pool Farm, Sheviock, to the existing 8" main from Eglaroose reservoir. The approval of the Ministry for this scheme was obtained towards the end of 1953, and work is to commence early in 1954.

The completion of both of the above schemes should ease the burden considerably during the summer months, which in 1953 was appreciably aided by the inclement weather, and consequently it was not necessary to restrict water supplies.

The erection of a baffle wall to facilitate the intermixing of copper suphalte and chloride of lime with the water, became necessary because of the increasing pollution of Eglaroose reservoir.

In addition, the reservoir at Carbeile Filter Beds was cleaned out, and Eglaroose reservoir was cleansed and the concrete retaining walls patched.

Sampling. 25 samples of raw and treated water have been taken during the year and submitted for bacteriological examination at the Public Health Laboratory. All the samples of treated water were shown to be sterile.

Samples of raw and treated water were submitted to the Public Analyst for chemical analysis and were found to be satisfactory.

Drainage and Sewerage

A special incident of note was the flooding due to surface water during heavy storms, at Clarence Place. This matter has received careful attention from both the County Council Highways Department and from this Council. Otherwise the sewerage system continued to function adequately.

Refuse Collection and disposal

Tipping commenced during 1953 on the new refuse tip at Borough Quarry, the old tip at Carbeile Mill having been closed. The weekly collection of refuse remains satisfactory, due in part to the serving of notices requiring householders to provide covered dustbins.

Housing

The erection of the twenty Council Houses and flats begun in 1952 was completed during the year, as was the erection of three Coronation Cottages. In addition, a start was made on a Contract for 44 Council Houses and flats. No houses were built by private enterprise.

All nuisances discovered were abated in a satisfactory manner, without recourse to prosecution.

Factories and Workshops

The 17 factories in the register were visited. No notices have been served.

Shops and Food Premises

There are 12 premises registered under the Food and Drugs Act for the sale of pre-packed ice-cream, one for the manufacture and sale of ice-cream, and one for the manufacture of sausages.

The approximate number of all food premises in the area is 37, which can be classed approximately as follows:-

2 Ice-cream only
9 Ice-cream, grocery and general stores.
2 Ice-cream, also restaurants.
4 Butchers shops
1 Guest House
9 Grocery and general stores.
3 Confectioners
1 Bakery
2 Fish and chip shops
1 Fish and chips and wet fish.
2 Greengrocery
1 Greengrocery and wet fish

There are no dairies registered in the area, but 5 retail distributors, the milk in four cases coming from Daws Creameries, Saltash, and in one from the Co-operative Dairy at Plymouth. All of the Milk is Pasteurised.

All food premises have been inspected regularly and this, together with suggestions made and the serving of informal notices, has led to a continued high state of cleanliness. Co-operation from shopkeepers has in most cases been good.

Sampling. Thirtysix samples of ice-crem were taken, thirtyfive of which were placed in Grade I, and one in Grade II. This sample was immediately followed up and resulted in further satisfactory Grade I samples.

Thirtynine samples of milk were taken, all of these being satisfactory. In addition, seven samples were taken for bacteriological tests, these also being satisfactory in that the inoculated guinea pigs showed no signs of infection with tuberculosis at post mortem examination.

The following amounts of food have been voluntarily surrendered as unsound:-

2 stones fish roe
7½ lb. cheese
6 lb. tin Ox Tongue
9 lb. Crab
3 lb. Lobster
11 lb. Ham
259 lb. Beef.

With the exception of the latter, which was returned to the Ministry of Food Slaughterhouse at Liskeard, the remainder was made good by the suppliers. There is no slaughterhouse within the Urban District.

Rodent Control

The usual 10% poison baiting check on the sewers, and poisoning on the Council's closed and newly-opened tip has taken place in conjunction with the Divisional Inspector of the Ministry of Agriculture & Fisheries. There is relatively no infestation in any of the cases.

Sanitary Inspections of the Area.

a. Total number of inspections made (all purposes)	1031
b. Informal notices served	24
" " complied with	17
c. Statutory notices served	1
" " complied with	0
d. Dustbin notices served	13
" " complied with	10
e. Drains tested	50
Number of visits re drainage	75
f. Visits re infectious diseases	5
Premises disinfected	2
g. Inspections of food premises	98
h. Inspections of shops under Shops Act, 1950.	102
i. Inspection of Factories	34

APPENDIX 1.

PRINCIPAL CAUSES OF DEATH - ALL AGES - 1953

DISEASE	St.Germans R.D.	Liskeard R.D.	Saltash M.B.	Torpoint U.D.	Liskeard M.B.	Looe U.D.	Health Area No.7
Heart Disease	65	72	33	12	67	17	266
Cancer(all sites)	37	23	11	10	10	14	105
Vascular lesions of the nervous system ('stroke')	10	19	19	6	15	3	72
Respiratory disease	19	11	5	4	4	3	46
Circulatory disease	9	3	5	3	3	2	25
Genito-urinary disease	3	5	5	-	2	1	16
Accidents	2	6	4	-	2	1	15
Digestive disease	4	4	3	2	-	-	13
Diabetes	4	1	3	-	1	-	9
Tuberculosis	2	2	3	-	1	-	8
Suicide	3	2	-	-	2	-	7

APPENDIX 2.

TYPES OF HEART DISEASE AND CANCER CUASING DEATH - 1953

TYPE OF DISEASE	St.Germans R.D.	Liskeard R.D.	Saltash M.B.	Torpoint U.D.	Liskeard M.B.	Looe U.D.	Health Area No.7
Coronary disease angina	28	23	10	3	7	4	75
Hypertension with Heart disease	5	5	4	-	4	3	21
Other heart disease	32	44	19	9	56	10	170
Cancer of stomach	9	4	1	1	3	3	21
Cancer of bronchus & lung	9	3	-	1	-	1	14
Cancer of breast	2	-	-	-	1	2	5
Cancer of womb	2	1	2	-	-	1	6
Other cancers	15	15	8	8	6	7	59

APPENDIX 3.

DEATHS BY AGE GROUPS - 1953

DISTRICT	0 - 5 years	5 - 15 years	15 - 45 years	45 - 65 years	65-75 years	75 years and upward	All Ages
ST. GERMANS R.D.	8	2	5	43	53	74	185
LISKEARD R.D.	8	-	6	35	42	78	169
SALTASH M.B.	6	-	7	23	26	46	108
TORPOINT U.D.	2	-	3	11	13	13	42
LISKEARD M.B.	-	-	2	18	26	72	118
LOOE U.D.	1	-	4	4	14	21	44
HEALTH AREA NO.7	25	2	27	134	174	304	666

APPENDIX 4.

AVERAGE AGE AT DEATH - 1953.

DISTRICT	MALES	FEMALES
ST. GERMANS R.D.	69	66
LISKEARD R.D.	65	72
SALTASH M.B.	65	65
TORPOINT U.D.	66	61
LISKEARD M.B.	74	78
LOOE U.D.	68	70
HEALTH AREA NO.7	68	69

APPENDIX 5

TUBERCULOSIS

INCIDENCE OF, AND MORTALITY FROM TUBERCULOSIS IN HEALTH AREA NO.7 - 1953

AGE GROUP	NEW CASES		DEATHS	
	M	F	M	F
0 - 1	-	-	-	-
1 - 5	3	1	1	-
5 - 15	5	7	-	-
15 - 45	15	15	1	1
45 - 65	9	3	2	1
65 years & upwards	5	-	2	-
TOTALS	37	26	6	2

	MALES.	FEMALES.
Case rate per 1000 of population (new cases)	0.69	0.49
Mortality rate per 1000 of population	0.11	0.04

Case rates and Mortality rates per 1000 of population by County Districts in Health Area No.7 - 1953

DISTRICT	New Cases	Total cases as at 31.12.53.	Deaths
ST.GERMANS R.D.	1.44	6.31	0.12
LISKEARD R.D.	0.71	5.33	0.14
SALTASH. M.B.	1.38	6.54	0.25
TORPOINT U.D.	1.34	6.26	-
LISKEARD M.B.	1.16	9.26	0.23
LOOE U.D.	1.11	5.85	-
HEALTH AREA NO.7	1.18	6.29	0.15

APPENDIX 6.

B.C.G. VACCINATIONS AGAINST TUBERCULOSIS - 1953

DISTRICT	UNDER 1 year	1 - 5 years	5 - 10 years	10 - 15 years	15 years and over
ST.GERMANS R.D.	8	9	7	6	1
LISKEARD R.D.	2	2	2	1	-
SALTASH M.B.	4	2	1	1	2
TORPOINT U.D.	3	10	10	3	-
LISKEARD M.B.	2	3	1	1	* 11
LOOE U.D.	1	3	3	1	1
HEALTH AREA NO.7	20	29	24	13	15

* Student Nurses at Wadham House Training Establishment.